HEALTH SYSTEM REFORM AMENDMENTS

2010 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill amends provisions related to health system reform for the insurance market, health care providers, the Health Code, and the Office of Consumer Health Services.

Highlighted Provisions:

This bill:

- provides access to the Department of Health's all payer database, for limited purposes, to the Insurance Department's health care delivery and health care payment reform demonstration project, and for the risk adjusting mechanism of the defined contribution insurance market;
- authorizes the all payer database to analyze the data it collects to provide consumer awareness of costs and transparency in the health care market including:
  - reports on geographic variances in medical costs; and
  - rate increases by providers or insurers that exceed the consumer price index within a 12 month period;
- clarifies the restrictions and protections for identifiable health information;
- consolidates statutory language requiring insurance department reports concerning the health insurance market;
- makes technical and clarifying amendments to the price and value comparison of health benefit plans;
- requires the insurance commissioner to convene a group to develop a method of comparing health insurers' claims denial rates and requires an administrative rule to implement the method;
- instructs the Insurance Department to continue its work with the Office of Consumer Health Services to develop additional demonstration projects for health care delivery and payment reform and to apply for available grants to implement and expand the demonstration projects;
- makes a technical amendment to the health plans an insurer may offer after July 1,

2012;

- requires the Insurance Department to:
  - convene a group to study simplification of the uniform health insurance application; and
  - develop a uniform waiver of coverage form;
- creates continuous open enrollment for employers in the defined contribution market and makes conforming amendments;
- allows a pilot program for a limited number of large groups to enter the defined contribution market by January 1, 2011;
- allows an insurer in the defined contribution market to offer a choice of health benefit plans that vary in actuarial value from plus or minus 15% from the actuarial value of the basic benefit package;
- creates a procedure in which a producer can be designated as an appointed agent for defined contribution arrangements on the Health Insurance Exchange;
- effective July 1, 2010, requires all insurers in the small employer group market to use the Health Insurance Exchange for enrollment and premium payments;
- effective July 1, 2010, modifies underwriting and rating practices in the small group market;
- makes technical amendments to the Defined Contribution Risk Adjuster Board;
- on July 1, 2011, repeals provisions related to certain small group rating practices;
- expands the risk adjusting mechanism in the Defined Contribution Market to the entire group market within the Health Insurance Exchange;
- requires health care providers to give consumers information about prices;
- requires the Health Insurance Exchange to create an advisory board of appointed producers and consumers;
- clarifies the type of information that an insurer must submit to the Health Insurance Exchange and to the Insurance Department; and
- re-authorizes the Health Reform Task Force for one year.

Monies Appropriated in this Bill:

None

Other Special Clauses:

This bill provides an effective date.

Utah Code Sections Affected:

AMENDS:

26-33a-106.1, as enacted by Laws of Utah 2007, Chapter 29

26-33a-109, as enacted by Laws of Utah 1990, Chapter 305

31A-2-201, as last amended by Laws of Utah 2008, Chapter 382

31A-22-613.5, as last amended by Laws of Utah 2009, Chapter 12

31A-22-614.6, as enacted by Laws of Utah 2009, Chapter 11

31A-22-618.5, as enacted by Laws of Utah 2009, Chapter 12

31A-22-635, as enacted by Laws of Utah 2008, Chapter 383

31A-30-103, as last amended by Laws of Utah 2009, Chapter 12

31A-30-203, as enacted by Laws of Utah 2009, Chapter 12

31A-30-204, as enacted by Laws of Utah 2009, Chapter 12

31A-30-205, as enacted by Laws of Utah 2009, Chapter 12

31A-30-207, as enacted by Laws of Utah 2009, Chapter 12

31A-42-201, as enacted by Laws of Utah 2009, Chapter 12

31A-42-202, as enacted by Laws of Utah 2009, Chapter 12

63M-1-2504, as last amended by Laws of Utah 2009, Chapter 12

63M-1-2506, as enacted by Laws of Utah 2009, Chapter 12

ENACTS:

26-21-26, Utah Code Annotated 1953

31A-2-201.2, Utah Code Annotated 1953

31A-30-209, Utah Code Annotated 1953

31A-30-210, Utah Code Annotated 1953

31A-30-211, Utah Code Annotated 1953

58-31b-802, Utah Code Annotated 1953

58-67-804, Utah Code Annotated 1953

58-68-804, Utah Code Annotated 1953

58-69-806, Utah Code Annotated 1953

REPEALS AND REENACTS:

31A-30-208, as enacted by Laws of Utah 2009, Chapter 12

REPEALS:

31A-30-105, as last amended by Laws of Utah 1995, Chapter 321

31A-30-106, as last amended by Laws of Utah 2008, Chapters 382, 383, and 385

31A-30-107.5, as last amended by Laws of Utah 2007, Chapter 307

Uncodified Material Affected:

ENACTS UNCODIFIED MATERIAL

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-21-26** is enacted to read:

26-21-26. Consumer access to facility charges.

A health care facility licensed under this chapter shall, when requested by a consumer:

(1) make a list of prices available for the consumer which includes the facility's

(a) in-patient procedures;

(b) out-patient procedures; and

(c) the 50 most commonly prescribed drugs in the facility; and

(2) provide the consumer with information regarding any discounts available for:

(a) charges for services not covered by insurance; or

(b) prompt payment of billed charges.

Section 2. Section **26-33a-106.1** is amended to read:

26-33a-106.1. Health care cost and reimbursement data.

(1) (a) The committee shall, as funding is available, establish an advisory panel to advise the committee on the development of a plan for the collection and use of health care data pursuant to Subsection 26-33a-104(6) and this section.

(b) The advisory panel shall include:

(i) the chairman of the Utah Hospital Association;

(ii) a representative of a rural hospital as designated by the Utah Hospital Association;

(iii) a representative of the Utah Medical Association;

(iv) a physician from a small group practice as designated by the Utah Medical Association;

(v) two representatives from the Utah Health Insurance Association;

(vi) a representative from the Department of Health as designated by the executive director of the department;

(vii) a representative from the committee;

(viii) a consumer advocate appointed by the committee;

(ix) a member of the House of Representatives appointed by the speaker of the House; and

(x) a member of the Senate appointed by the president of the Senate.

(c) The advisory panel shall elect a chair from among its members, and shall be staffed by the committee.

(2) (a) The committee shall, as funding is available[~~,~~];

(i) establish a plan for collecting data from data suppliers, as defined in Section 26-33a-102, to determine measurements of cost and reimbursements for risk adjusted episodes of health care[~~.~~];

(ii) subject to Section 26-33a-109, assist the demonstration project implemented by the Insurance Department pursuant to Section 31A-22-614.6, with access to cost data, reimbursement data, care process data, and provider service data necessary for the demonstration project's research and statistical analysis;

(iii) notwithstanding Section 26-33a-109, share data regarding insurance claims with insurers participating in the defined contribution market created in Title 31A, Chapter 30, Part 2 "Defined Contribution Arrangements" only to the extent:

(A) necessary for:

(I) renewals of policies in the defined contribution market; and

(II) risk adjusting in the defined contribution market; and

(B) allowed by the provisions of the Health Insurance Portability and Accountability Act of 1996, Pub. L.104-191,110 stat.1996; and

(iv) assist the Legislature and the public with awareness of, and the promotion of transparency in the health care market by reporting on:

(A) geographic variances in medical care and costs as demonstrated by data available to the committee; and

(B) rate and price increases by health care providers or health insurers that exceeds the consumer price index within a 12 month period as demonstrated by data available to the

committee.

(b) The plan adopted under this Subsection (2) shall include:

(i) the type of data that will be collected;

(ii) how the data will be evaluated;

(iii) how the data will be used;

(iv) the extent to which, and how the data will be protected; and

(v) who will have access to the data.

Section 3. Section **26-33a-109** is amended to read:

26-33a-109. Exceptions to prohibition on disclosure of identifiable health data.

(1) The committee may not disclose any identifiable health data unless:

[~~(1)~~] (a) the individual has consented to the disclosure; or

[~~(2)~~] (b) the disclosure [~~is to any~~] complies with the provisions of this section.

(2) (a) The committee shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996, Pub. L.104-191,110 stat.1996, when responding to a request for disclosure of information that may include identifiable health data.

(b) In addition to the requirements of Subsection (2)(a), the committee shall consider the following when responding to a request for disclosure of information that may include identifiable health data:

(i) whether the request comes from an organization that has an institutional review board[~~,~~]; and

(ii) whether the requesting entity can comply with the provisions of Subsection (3).

(3) A request for disclosure of information that may include identifiable health data shall:

(a) be for a specified period[~~,~~]; and

(b) be solely for bona fide research and statistical purposes[~~,~~] as determined in accordance with administrative rules adopted by the department [~~rules, and~~], which shall require;

(i) the requesting entity to demonstrate to the department [~~determines~~] that the data is required for the research and statistical purposes proposed by the requesting entity; and

(ii) the requesting [~~individual or organization enters~~] entity to enter into a written agreement satisfactory to the department to protect the data in accordance with this chapter or

other applicable law [~~and not permit further disclosure~~].

(4) A person with access to identifiable health data pursuant to Subsection (3) may not further disclose the identifiable health data:

(a) without prior approval of the department[~~. Any~~]; and

(b) unless the identifiable health data is disclosed [~~shall be~~] or identified by control number only.

Section 4. Section **31A-2-201** is amended to read:

31A-2-201. General duties and powers.

(1) The commissioner shall administer and enforce this title.

(2) The commissioner has all powers specifically granted, and all further powers that are reasonable and necessary to enable the commissioner to perform the duties imposed by this title.

(3) (a) The commissioner may make rules to implement the provisions of this title according to the procedures and requirements of Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) In addition to the notice requirements of Section 63G-3-301, the commissioner shall provide notice under Section 31A-2-303 of hearings concerning insurance department rules.

(4) (a) The commissioner shall issue prohibitory, mandatory, and other orders as necessary to secure compliance with this title. An order by the commissioner is not effective unless the order:

(i) is in writing; and

(ii) is signed by the commissioner or under the commissioner's authority.

(b) On request of any person who would be affected by an order under Subsection (4)(a), the commissioner may issue a declaratory order to clarify the person's rights or duties.

(5) (a) The commissioner may hold informal adjudicative proceedings and public meetings, for the purpose of:

(i) investigation;

(ii) ascertainment of public sentiment; or

(iii) informing the public.

(b) An effective rule or order may not result from informal hearings and meetings

unless the requirement of a hearing under this section is satisfied.

(6) The commissioner shall inquire into violations of this title and may conduct any examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, that the commissioner considers proper to determine:

(a) whether or not any person has violated any provision of this title; or

(b) to secure information useful in the lawful administration of this title.

[~~(7) (a) Each year, the commissioner shall:~~]

[~~(i) conduct an evaluation of the state's health insurance market;~~]

[~~(ii) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1; and~~]

[~~(iii) publish the findings of the evaluation on the department website.~~]

[~~(b) The evaluation required by Subsection (7)(a) shall:~~]

[~~(i) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of Utahns by assessing such things as:~~]

[~~(A) the availability and marketing of individual and group products;~~]

[~~(B) rate charges;~~]

[~~(C) coverage and demographic changes;~~]

[~~(D) benefit trends;~~]

[~~(E) market share changes; and~~]

[~~(F) accessibility;~~]

[~~(ii) assess complaint ratios and trends within the health insurance market, which assessment shall integrate complaint data from the Office of Consumer Health Assistance within the department;~~]

[~~(iii) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and~~]

[~~(iv) include claims loss ratio data for each insurance company doing business in the state.~~]

[~~(c) When preparing the evaluation required by this Subsection (7), the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.~~]

Section 5. Section **31A-2-201.2** is enacted to read:

31A-2-201.2. Evaluation of Health Insurance Market.

(1) Each year, the commissioner shall:

(a) conduct an evaluation of the state's health insurance market;

(b) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1 of each year; and

(c) publish the findings of the evaluation on the department website.

(2) The evaluation required by this section shall:

(a) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of the state including:

(i) the availability and marketing of individual and group products;

(ii) rate changes;

(iii) coverage and demographic changes;

(iv) benefit trends;

(v) market share changes; and

(vi) accessibility;

(b) assess complaint ratios and trends within the health insurance market, which assessment shall integrate complaint data from the Office of Consumer Health Assistance within the department;

(c) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and

(d) include claims loss ratio data for each health insurance company doing business in the state.

(3) When preparing the evaluation required by this section, the commissioner shall include a report of:

(a) the types of health benefit plans sold on the Health Insurance Exchange created in Section 63M-1-2504;

(b) the number of insurers participating in the defined contribution market on the Health Insurance Exchange;

(c) the number of employers and covered lives in the defined contribution market; and

(d) the number of lives covered by health benefit plans that do not include state

mandates as permitted by Subsection 31A-30-109(2).

(4) When preparing the evaluation and report required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

(5) The commissioner may adopt administrative rules for the purpose of collecting the data required by this section taking into account the business confidentiality of the insurers.

Section 6. Section **31A-22-613.5** is amended to read:

31A-22-613.5. Price and value comparisons of health insurance -- Basic Health Care Plan.

(1) (a) [~~Except as provided in Subsection (1)(b), this~~] This section applies to all health [~~insurance policies and health maintenance organization contracts~~] benefit plans.

(b) Subsection (2) applies to:

(i) all [~~health insurance policies and health maintenance organization contracts~~] health benefit plans; and

(ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

(2) (a) The commissioner shall promote informed consumer behavior and responsible [~~health insurance and~~] health benefit plans by requiring an insurer issuing [~~health insurance policies or health maintenance organization contracts~~] a health benefit plan to:

(i) provide to all enrollees, prior to enrollment in the health benefit plan [~~or health insurance policy,~~] written disclosure of:

[~~(i)~~] (A) restrictions or limitations on prescription drugs and biologics including the use of a formulary and generic substitution;

[~~(ii)~~] (B) coverage limits under the plan; and

[~~(iii)~~] (C) any limitation or exclusion of coverage including:

[~~(A)~~] (I) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and

[~~(B)~~] (II) [~~beginning July 1, 2009,~~] easily understood examples of a limitation or exclusion of coverage for a secondary medical condition[~~.~~]; and

(ii) provide the commissioner with:

(A) the information described in Subsections 63M-1-2506(3), (4), and (5) in the standardized electronic format required by Subsection 63M-1-2506(1); and

(B) information regarding the insurer's claims denial rates as determined under Subsection (5) of this section.

(b) [~~In addition to the requirements of Subsections (2)(a), (d), and (e) an insurer described in Subsection (2)(a)~~] An insurer shall file the written disclosure required by [~~this~~] Subsection (2)(a)(i) [~~to~~] with the commissioner:

(i) upon commencement of operations in the state; and

(ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):

(A) treatment policies;

(B) practice standards;

(C) restrictions;

(D) coverage limits of the insurer's health benefit plan or health insurance policy; or

(E) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

[~~(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection (2), taking into account:~~]

[~~(i) business confidentiality of the insurer;~~]

[~~(ii) definitions of terms;~~]

[~~(iii) the method of disclosure to enrollees; and~~]

[~~(iv) limitations and exclusions.~~]

[~~(d)~~] (c) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included;

(iii) any conditions that exist as a precedent to coverage; and

(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.

[~~(c)~~] (d) (i) The department shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(a)[~~(iii)~~](i)(C).

(ii) Examples of a limitation or exclusion of coverage provided under Subsection (2)(a)[~~(iii)~~](i)(C) or otherwise are for illustrative purposes only, and the failure of a particular

fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

(3) An insurer who offers a health care plan under Chapter 30, Individual, Small Employer, and Group Health Insurance Act, shall[~~: (a) until January 1, 2010, offer the basic health care plan described in Subsection (4) subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and (b) beginning January 1, 2010,~~] offer a basic health care plan subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act, that:

(i) is a federally qualified high deductible health plan;

(ii) has the lowest deductible that qualifies under a federally qualified high deductible health plan, as adjusted by federal law; and

(iii) does not exceed an annual out of pocket maximum equal to three times the amount of the annual deductible.

[~~(4) Until January 1, 2010, the Basic Health Care Plan under this section shall provide for:~~]

[~~(a) a lifetime maximum benefit per person not less than $1,000,000;~~]

[~~(b) an annual maximum benefit per person not less than $250,000;~~]

[~~(c) an out-of-pocket maximum of cost-sharing features:~~]

[~~(i) including:~~]

[~~(A) a deductible;~~]

[~~(B) a copayment; and~~]

[~~(C) coinsurance;~~]

[~~(ii) not to exceed $5,000 per person; and~~]

[~~(iii) for family coverage, not to exceed three times the per person out-of-pocket maximum provided in Subsection (4)(c)(ii);~~]

[~~(d) in relation to its cost-sharing features:~~]

[~~(i) a deductible of:~~]

[~~(A) not less than $1,000 per person for major medical expenses; and~~]

[~~(B) for family coverage, not to exceed three times the per person deductible for major medical expenses under Subsection (4)(d)(i)(A); and~~]

[~~(ii) (A) a copayment of not less than:~~]

[~~(I) $25 per visit for office services; and~~]

[~~(II) $150 per visit to an emergency room; or~~]

[~~(B) coinsurance of not less than:~~]

[~~(I) 20% per visit for office services; and~~]

[~~(II) 20% per visit for an emergency room; and~~]

[~~(c) in relation to cost-sharing features for prescription drugs:~~]

[~~(i) (A) a deductible not to exceed $1,000 per person; and~~]

[~~(B) for family coverage, not to exceed three times the per person deductible provided in Subsection (4)(c)(i)(A); and~~]

[~~(ii) (A) a copayment of not less than:~~]

[~~(I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for prescription drugs;~~]

[~~(II) the lesser of the cost of the prescription drug or $25 for the second level of cost for prescription drugs; and~~]

[~~(III) the lesser of the cost of the prescription drug or $35 for the highest level of cost for prescription drugs; or~~]

[~~(B) coinsurance of not less than:~~]

[~~(I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for prescription drugs;~~]

[~~(II) the lesser of the cost of the prescription drug or 40% for the second level of cost for prescription drugs; and~~]

[~~(III) the lesser of the cost of the prescription drug or 60% for the highest level of cost for prescription drugs.~~]

[~~(5) The department shall include in its yearly insurance market report information about:~~]

[~~(a) the types of health benefit plans sold on the Internet portal created in Section 63M-1-2504;~~]

[~~(b) the number of insurers participating in the defined contribution market on the Internet portal;~~]

[~~(c) the number of employers and covered lives in the defined contribution market; and~~]

[~~(d) the number of lives covered by health benefit plans that do not include state mandates as permitted by Subsection 31A-30-109(2).~~]

[~~(6)~~] (4) The commissioner:

(a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to the Health Insurance Exchange created under Subsection 63M-1-2504; and

(b) may request information from an insurer to verify the information submitted by the insurer [~~to the Internet portal under Subsection 63M-1-2506(4)~~] under this section.

(5) The commissioner:

(a) shall:

(i) convene a group of insurers and consumers to develop a method of calculating and comparing insurers' claims denials for health benefit plans that is understandable and meaningful to consumers; and

(ii) adopt an administrative rule that establishes the methodology for determining and comparing insurers' claim denials; and

(b) may adopt administrative rules to:

(i) implement the disclosure requirements of Subsection (2), taking into account:

(A) business confidentiality of the insurer;

(B) definitions of terms;

(C) the method of disclosure to enrollees; and

(D) limitations and exclusions; and

(ii) to establish standards for submission of the information required by Section 63M-1-2506.

Section 7. Section **31A-22-614.6** is amended to read:

31A-22-614.6. Health care delivery and payment reform demonstration projects.

(1) The Legislature finds that:

(a) current health care delivery and payment systems do not provide systemwide aligned incentives for the appropriate delivery of health care;

(b) some health care providers and health care payers have developed ideas for health care delivery and payment system reform, but lack the critical number of patient lives and payer involvement to accomplish systemwide reform; and

(c) there is a compelling state interest to encourage as many health care providers and

health care payers to join together and coordinate efforts at systemwide health care delivery and payment reform.

(2) (a) The Office of Consumer Health Services within the Governor's Office of Economic Development shall convene meetings of health care providers and health care payers through a neutral, non-biased entity that can demonstrate it has the support of a broad base of the participants in this process for the purpose of coordinating broad based demonstration projects for health care delivery and payment reform.

(b) (i) The speaker of the House of Representatives may appoint a person who is a member of the House of Representatives, or from the Office of Legislative Research and General Counsel, to attend the meetings convened under Subsection (2)(a).

(ii) The president of the Senate may appoint a person who is a senator, or from the Office of Legislative Research and General Counsel, to attend the meetings convened under Subsection (2)(a).

(c) Participation in the coordination efforts by health care providers and health care payers is voluntary, but is encouraged.

(3) The commissioner and the Office of Consumer Health Services shall facilitate several coordinated broad based demonstration projects for health care delivery reform and health care payment reform between various health care providers and health care payers who elect to participate in the demonstration projects by:

(a) consulting with health care providers and health care payers who elect to join together in a broad based reform demonstration project; [~~and~~]

(b) consulting with a neutral, non-biased third party with an established record for broad based, multi-payer and multi-provider quality assurance efforts and data collection;

(c) applying for grants and assistance that may be available for creating and implementing the demonstration projects; and

[~~(b)~~] (d) adopting administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to implement the demonstration [~~project~~] projects.

(4) The Office of Consumer Health Services and the commissioner shall report to the Health Reform Task Force by October [~~2009~~] 2010, and to the Legislature's Business and Labor Interim Committee every October thereafter regarding the progress towards coordination

of broad based health care system payment and delivery reform.

Section 8. Section **31A-22-618.5** is amended to read:

31A-22-618.5. Health plan offerings.

(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may offer to a potential purchaser one or more health benefit plans that:

(i) are not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

(B) the limitation on point of service products in Subsections 31A-8-408(3) through (6);

(C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or

(D) coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627 as follows:

(A) within the organization's service area, covered services shall include health care services from non-affiliated providers when medically necessary to stabilize an emergency medical condition; and

(B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that groups providers into the following reimbursement levels:

(i) tier one contracted providers;

(ii) tier two contracted providers who the insurer must reimburse at least 75% of tier one providers; and

(iii) one or more tiers of non-contracted providers; and

(b) notwithstanding Subsection 31A-22-617(9)may offer a health benefit plan that is not subject to [~~Subsection 31A-22-617(9) and~~] Section 31A-22-618;

(c) beginning July 1, 2012, may offer products under Subsection (3)(a) that:

(i) are not subject to Subsection 31A-22-617(2); and

(ii) are subject to the reimbursement requirements in Section 31A-8-501;

(d) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627 by providing coverage at a reimbursement level of at least 75% of tier one providers; and

(e) are not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5) (a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.

(b) Any difference in price between a health benefit plan offered under Subsections (3)(a) and (b) shall be based on actuarially sound data.

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Section 9. Section **31A-22-635** is amended to read:

31A-22-635. Development of uniform health insurance applications.

(1) For purposes of this section, "insurer":

(a) is defined in Subsection 31A-22-634(1); and

(b) includes the state employee's risk pool under Section 49-20-202.

(2) (a) [~~Beginning July 1, 2009, all insurers~~] Insurers offering [~~health insurance~~] a

health benefit plan to an individual or small employer shall:

(i) beginning July 1, 2009, use a uniform application form[-], which, may not include questions about an applicant's health history prior to the previous 10 years; and

(ii) use a uniform waiver of coverage form, which:

(A) may not include health status related questions other than pregnancy; and

(B) is limited to:

(I) information that identifies the employee;

(II) proof of the employee's insurance coverage; and

(III) a statement that the employee declines coverage with a particular employer group.

(b) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may be combined or modified to facilitate:

(i) the electronic submission and processing of an application through the Health Insurance Exchange created pursuant to Section 63M-1-2504; and

(ii) a more efficient and understandable experience for a consumer submitting an application in the Health Insurance Exchange.

(3) (a) The uniform application form, uniform waiver form, and any modification to the forms under Subsection (2)(b) shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) The commissioner shall [~~consult with~~] convene the health insurance industry [~~when adopting the uniform application form~~], the Office of Consumer Health Services, health care providers, and consumers to review the uniform application and determine if the application can be shortened and simplified. The department shall report the findings of the group convened pursuant to this subsection to the Legislature no later than July 1, 2010.

(4) (a) Beginning July 1, 2010, [~~all insurers~~] an insurer who offers a health benefit plan on the Health Insurance Exchange created in Section 63M-1-2504, shall [~~offer compatible systems of electronic submission of application forms, approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. The systems approved by the commissioner may include monitoring and disseminating information concerning eligibility and coverage of individuals.~~]:

(i) accept and process an electronic submission of the uniform application or uniform waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to

Section 63M-1-2506; and

(ii) provide the applicant with a copy of the completed application either by mail or electronically.

(b) The commissioner shall regulate any fees charged by insurers to an enrollee for a uniform application form or electronic submission of the application forms.

Section 10. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with Section 31A-30-106, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

[~~(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.~~]

[~~(4)~~] (3) "Basic coverage" means the coverage provided in the Basic Health Care Plan under Section 31A-22-613.5.

[~~(5)~~] (4) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

[~~(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the~~

~~carrier in determining premium rates for the covered insured.~~]

[~~(b) "Case characteristics" do not include:~~]

[~~(i) duration of coverage since the policy was issued;~~]

[~~(ii) claim experience; and~~]

[~~(iii) health status.~~]

[~~(7) "Class of business" means all or a separate grouping of covered insureds established under Section 31A-30-105.~~]

[~~(8)~~] (5) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

[~~(9)~~] (6) "Covered carrier" means any individual carrier or small employer carrier subject to this chapter.

[~~(10)~~] (7) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.

[~~(11)~~] (8) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

[~~(12)~~] (9) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

[~~(13)~~] (10) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

[~~(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.~~]

[~~(15)~~] (11) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

[~~(16)~~] (12) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

[~~(17)~~] (13) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.

[~~(18)~~] (14) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

[~~(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.~~]

[~~(20)~~] (15) "Plan year" means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is not a plan document, the plan year is:

(a) the deductible or limit year used under the plan;

(b) if the plan does not impose a deductible or limit on a yearly basis, the policy year;

(c) if the plan does not impose a deductible or limit on a yearly basis and either the plan is not insured or the insurance policy is not renewed on an annual basis, the employer's taxable year; or

(d) in any case not described in Subsections [~~(20)~~] (15)(a) through (c), the calendar year.

[~~(21)~~] (16) "Preexisting condition" is as defined in Section 31A-1-301.

[~~(22)~~] (17) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

[~~(23)~~] (18) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

[~~(24)~~] (19) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

[~~(25)~~] (20) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

[~~(26)~~] (21) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

[~~(27)~~] (22) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i) and (j) for which coverage the applicant is applying.

[~~(28)~~] (23) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and

(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.

Section 11. Section **31A-30-203** is amended to read:

31A-30-203. Eligibility for defined contribution arrangement market -- Enrollment.

(1) (a) [~~Beginning January 1, 2010, and during the open enrollment period described in Section 31A-30-208, an~~] An eligible small employer may choose to [~~participate in~~] offer its employees a defined contribution arrangement.

(b) (i) Beginning January 1, 2011 and during the open enrollment period, an eligible large employer participating in the demonstration project under Section 31A-30-208 may chose to participate in a defined contribution arrangement.

[~~(b)~~] (ii) Beginning January 1, 2012, [~~and during the open enrollment period described in Section 31A-30-208,~~] an eligible large employer may choose to participate in a defined contribution arrangement.

(c) Defined contribution arrangement health benefit plans are employer group health plans individually selected by an employee of an employer.

(2) (a) Participating insurers:

(i) shall offer to accept all eligible employees of an employer described in Subsection (1), and their dependents, at the same level of benefits as anyone else who has the same health benefit plan in the defined contribution arrangement market[~~; and~~].

[~~(ii) may not impose a premium surcharge under Section 31A-30-106.7 in the defined contribution market.~~]

(b) A participating insurer may:

(i) request an employer to submit a copy of the employer's quarterly wage list to determine whether the employees for whom coverage is provided or requested are bona fide employees of the employer; and

(ii) deny or terminate coverage if the employer refuses to provide documentation requested under Subsection (2)(b)(i).

Section 12. Section **31A-30-204** is amended to read:

31A-30-204. Employer responsibilities -- Defined contribution arrangements.

(1) (a) (i) An employer described in Subsection 31A-30-203(1) that chooses to participate in a defined contribution arrangement may not offer to an employee a major medical health benefit plan that is not a part of the defined contribution arrangement [~~to an employee~~] market.

(ii) Subsection (1)(a)(i) does not prohibit the offer of supplemental or limited benefit policies such as dental or vision coverage, or other types of federally qualified savings accounts

for health care expenses.

(b) (i) To the extent permitted by Sections 31A-1-301, 31A-30-112, 31A-30-203, 31A-30-206, and the risk adjustment plan adopted under Section 31A-42-202, the employer reserves the right to determine:

(A) the criteria for employee eligibility, enrollment, and participation in the employer's health benefit plan; and

(B) the amount of the employer's contribution to that plan.

(ii) The determinations made under Subsection (1)(b) may only be changed during periods of open enrollment.

(2) An employer that chooses to establish a defined contribution arrangement to provide a health benefit plan for its employees shall:

(a) establish a mechanism for its employees to use pre-tax dollars to purchase a health benefit plan from the defined contribution arrangement market on the [~~Internet portal~~] Health Insurance Exchange created in Section 63M-1-2504, which may include:

(i) a health reimbursement arrangement;

(ii) a Section 125 Cafeteria plan; or

(iii) another plan or arrangement similar to Subsection (2)(a)(i) or (ii) which is excluded or deducted from gross income under the Internal Revenue Code;

(b) [~~by November 10 of the open enrollment period~~] at least 15 days before the employee's health benefit plan selection period:

(i) inform each employee of the health benefit plan the employer has selected as the default health benefit plan for the employer group;

(ii) offer each employee a choice of any of the health benefit plans available through the defined contribution arrangement market on the [~~Internet portal~~] Health Insurance Exchange; and

(iii) notify the employee that the employee will be enrolled in the default health benefit plan selected by the employer and payroll deductions initiated for premium payments, unless the employee, [~~prior to November 25 of the open enrollment period~~] before the employee's selection period ends:

(A) notifies the employer that the employee has selected a different health benefit plan available through the defined contribution arrangement in the [~~Internet portal~~] Health Insurance

Exchange;

(B) provides proof of coverage from another health benefit plan; or

(C) specifically declines coverage in a health benefit plan.

(3) An employer shall enroll an employee in the default health benefit plan selected by the employer if the employee does not make one of the choices described in Subsection (2)(b)(ii) [~~prior to November 25 of the open enrollment period~~] before the end of the employee selection period, which may not be less than 14 calendar days.

(4) The employer's notice to the employee under Subsection (2)(b)(iii) shall inform the employee that the failure to act under Subsections (2)(b)(iii)(A) through (C) is considered an affirmative election under pre-tax payroll deductions for the employer to begin payroll deductions for health benefit plan premiums.

Section 13. Section **31A-30-205** is amended to read:

31A-30-205. Health benefit plans offered in the defined contribution market.

(1) An insurer who [~~chooses to offer a health benefit plan in the~~] offers a defined contribution [~~market must~~] arrangement shall offer the following health benefit plans as defined contribution arrangements:

(a) one health benefit plan that:

(i) is a federally qualified high deductible health plan;

(ii) has the lowest deductible permitted for a federally qualified high deductible health plan as adjusted by federal law; and

(iii) does not exceed annual out-of-pocket maximum equal to three times the amount of the annual deductible; and

(b) one health benefit plan with benefits that have an actuarial value at least 15% greater that the plan described in Subsection (1)(a).

(2) (a) The provisions of Subsection (1) do not limit the number of health benefit plans an insurer may offer in the defined contribution market.

(b) An insurer who offers the health benefit plans required by Subsection (1) may also offer any other health benefit plan [~~in the~~] as a defined contribution [~~market~~] arrangement if:

(i) the health benefit plan provides benefits that are [~~actuarially richer~~] of greater actuarial value than the benefits required in Subsection (1)(a)[~~.~~]; or

(ii) the health benefit plan provides benefits with an aggregate actuarial value that is no

more than 15% lower than the actuarial value of the benefits required in Subsection (1)(a).

Section 14. Section **31A-30-207** is amended to read:

31A-30-207. Rating and underwriting restrictions for defined contribution market.

(1) The rating and underwriting restrictions for [~~the~~] a defined contribution [~~market~~] arrangement shall be established in accordance with the plan adopted under Chapter 42, Defined Contribution Risk Adjuster Act, and shall apply to employers who participate in the defined contribution arrangement [~~market~~].

(2) [~~All insurers~~] An insurer who [~~participate in the~~] offers a defined contribution [~~market must~~] arrangement shall participate in the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster Act.

Section 15. Section **31A-30-208** is repealed and reenacted to read:

31A-30-208. Open Enrollment for defined contribution arrangements.

An insurer offering a defined contribution arrangement:

(1) beginning on or after May 1, 2010, shall offer continuous open enrollment for small employer groups for defined contribution arrangements;

(2) may not impose a surcharge under Section 31A-30-106.7 for a small employer group selecting a defined contribution arrangement on or before July 1, 2010;

(3) shall offer a limited pilot program for open enrollment for large employer groups to select a defined contribution arrangement that takes effect January 1, 2011; and

(4) beginning January 1, 2012, shall offer continuous open enrollment for large employer groups to select a defined contribution arrangement.

Section 16. Section **31A-30-209** is enacted to read:

31A-30-209. Appointment of insurance producers to Health Insurance Exchange.

(1) A producer may be listed on the Health Insurance Exchange as a producer for defined contribution arrangements in accordance with Section 63M-1-2504, if the producer is designated as an appointed agent for the exchange in accordance with Subsection (2).

(2) A producer whose license under this title authorizes the producer to sell defined contribution arrangements may be appointed to the Health Insurance Exchange if the producer:

(a) submits an application to be appointed as a producer for the Health Insurance Exchange;

(b) is an appointed agent with each of the carriers that offer a defined contribution arrangement on the Health Insurance Exchange; and

(c) has completed a training session on the Health Insurance Exchange that is an approved training session as designated by the commissioner by administrative rule.

Section 17. Section **31A-30-210** is enacted to read:

31A-30-210. Use of Health Insurance Exchange for Defined Benefit Health Plans and Defined Contribution Arrangements.

(1) Beginning January 1, 2011, an insurer offering a health benefit plan to a small employer group in the state:

(a) shall, except as provided in Subsection (3), offer a defined contribution arrangement to an employer in accordance with this part;

(b) may offer a health benefit plan to a small employer group as a defined benefit plan in accordance with this section; and

(c) may not, after July 1, 2010, renew a small employer defined benefit health benefit plan or offer a new small employer defined benefit health benefit plan in the state, except as provided in Subsection (2).

(2) Beginning July 1, 2010, a health benefit plan offered to a small employer group shall:

(a) use the Health Insurance Exchange established under Section 63M-1-2504 as the enrollment tool and premium payment system for the plan;

(b) use the premium rating methodology established in Section 31A-30-211; and

(c) participate in the risk adjuster mechanism established by the Risk Adjuster Board, created in Chapter 42, Defined Contribution Risk Adjuster Act.

(3) A health benefit plan that is not offered to the general public, such as a health benefit plan offered by an association, shall participate in the Health Insurance Exchange for the purpose of:

(a) enrolling its members and premium payments; and

(b) participating in the risk adjuster mechanism created in Chapter 42, Defined Risk Adjuster Act.

Section 18. Section **31A-30-211** is enacted to read:

31A-30-211. Premiums-Rating Restrictions- Defined Contribution Arrangements

and Defined Benefit Health Plans.

Beginning July 1, 2010, an insurer who offers a health benefit plan to a small employer group in the state:

(1) except as provided in Subsection (2), may not use the health status of an enrollee for the purpose of calculating premium rates; and

(2) may use the following factors in calculating a premium rate:

(a) age;

(b) geographic area; and

(c) consumer responsibility for health and wellness, which includes:

(i) participation in wellness programs;

(ii) tobacco usage;

(iii) body mass index;

(iv) management of cholesterol levels;

(v) management of blood pressure; and

(vi) management of diabetes.

Section 19. Section **31A-42-201** is amended to read:

31A-42-201. Creation of defined contribution market risk adjuster mechanism -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.

(1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity within the [~~Insurance Department~~] department.

(2) (a) The risk adjuster [~~shall be~~] is under the direction of a board of directors composed of up to nine members described in Subsection (2)(b).

(b) [~~The following directors shall be~~] The board of directors shall consist of:

(i) the following directors appointed by the governor with the consent of the Senate:

[~~(i)~~] (A) at least three, but up to five, directors with actuarial experience who represent [~~insurance carriers~~] insurers:

[~~(A)~~] (I) that are participating or have committed to participate in the defined contribution arrangement market in the state; and

[~~(B)~~] (II) including at least one and up to two directors who represent [~~a carrier~~] an insurer that has a small percentage of lives in the defined contribution market;

[~~(ii)~~] (B) one director who represents either an individual employee or employer

[participant in the defined contribution market]; and

[(iii)] (C) one director [appointed by the governor to represent] who represents the Office of Consumer Health Services within the Governor's Office of Economic Development;

[(iv)] (ii) one director representing the Public Employee's Health [Benefit] Program with actuarial experience, chosen by the director of the Public Employee's Health [Benefit] Program [who shall serve as an ex officio member]; and

[(v)] (iii) the commissioner, or a representative [from the department with actuarial experience] of the commissioner who:

(A) is appointed by the commissioner; and

(B) has actuarial experience.

(c) The commissioner or a representative appointed by the commissioner, [who will only have voting privileges] may vote only in the event of a tie vote.

(3) (a) Except as required by Subsection (3)(b), as terms of current board members appointed by the governor expire, the governor shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(4) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term in the same manner as the original appointment was made.

(5) (a) Members who are not government employees shall receive no compensation or benefits for the members' services.

(b) A state government member who is a member because of the member's state government position may not receive per diem or expenses for the member's service.

(6) The board shall elect annually a chair and vice chair from its membership.

(7) Six board members are a quorum for the transaction of business.

(8) The action of a majority of the members of the quorum is the action of the board.

Section 20. Section **31A-42-202** is amended to read:

31A-42-202. Contents of plan.

(1) The board shall submit a plan of operation for the risk adjuster to the

commissioner. The plan shall:

(a) establish the methodology for implementing:

(i) Subsection (2) for the defined contribution arrangement market established under Chapter 30, Part 2, Defined Contribution Arrangements;

(ii) beginning July 1, 2010:

(A) the participation of defined benefit health plans and defined contribution health plans for small employer groups in:

(I) the Health Insurance Exchange; and

(ii) the risk adjuster mechanism created by this chapter; and

(B) the modified rating practices required by Section 31A-30-211; and

(iii) beginning January 1, 2011, the participation of large employer groups in the defined contribution market and the risk adjuster mechanism created by this chapter;

(b) establish regular times and places for meetings of the board;

(c) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;

(d) contain additional provisions necessary and proper for the execution of the powers and duties of the risk adjuster; and

(e) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred.

(2) (a) The plan adopted by the board for the defined contribution arrangement market shall include:

(i) parameters an employer may use to designate eligible employees for the defined contribution arrangement market; and

(ii) underwriting mechanisms and employer eligibility guidelines:

(A) consistent with the federal Health Insurance Portability and Accountability Act; and

(B) necessary to protect insurance carriers from adverse selection in the defined contribution market.

(b) The plan required by Subsection (2)(a) shall outline how premium rates for a qualified individual are determined, including:

(i) the identification of an initial rate for a qualified individual based on:

(A) standardized age bands submitted by participating insurers; and

[~~(B) wellness incentives for the individual as permitted by federal law; and~~]

[~~(ii) the identification of a group risk factor to be applied to the initial age rate of a qualified individual based on the health conditions of all qualified individuals in the same employer group and, for small employers, in accordance with Sections 31A-30-105 and 31A-30-106.~~]

(B) personal responsibility factors permitted by Section 31A-30-211.

(c) The plan adopted under Subsection (2)(a) shall outline how:

(i) premium contributions for qualified individuals shall be submitted to the [~~Internet portal~~] Health Insurance Exchange in the amount determined under Subsection (2)(b); and

(ii) the [~~Internet portal~~] Health Insurance Exchange shall distribute premiums to the insurers selected by qualified individuals within an employer group based on each individual's [~~health risk~~] rating factor determined in accordance with the plan.

(d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting risk between insurers that:

(i) identifies [~~health care conditions~~] factors subject to risk adjustment;

(ii) establishes an adjustment amount for each identified [~~health care condition~~] factor;

(iii) determines the extent to which an insurer has more or less individuals with an identified [~~health condition~~] factor than would be expected; and

(iv) computes all risk adjustments.

(e) The board may amend the plan if necessary to:

(i) maintain the solvency of the defined contribution market;

(ii) maintain the solvency of the defined benefit small employer group market participating in the Health Insurance Exchange;

[~~(ii)~~] (iii) mitigate significant issues of risk selection; or

[~~(iii)~~] (iv) improve the administration of the risk adjuster mechanism.

Section 21. Section **58-31b-802** is enacted to read:

58-31b-802. Consumer access to provider charges.

A nurse whose license under this chapter authorizes independent practice shall, when requested by a consumer:

(1) make a list of professional charges available for the consumer which includes the

nurse's 25 most frequently performed:

(a) clinical procedures or clinical services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 22. Section **58-67-804** is enacted to read:

58-67-804. Consumer access to provider charges.

A physician licensed under this chapter shall, when requested by a consumer:

(1) make a list of professional charges available for the consumer which includes the physician's 25 most frequently performed:

(a) clinical procedures or clinical services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 23. Section **58-68-804** is enacted to read:

58-68-804. Consumer access to provider charges.

An osteopathic physician licensed under this chapter shall, when requested by a consumer:

(1) make a list of professional charges available for the consumer which includes the osteopathic physician's 25 most frequently performed:

(a) clinical procedures or clinical services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 24. Section **58-69-806** is enacted to read:

58-69-806. Consumer access to provider charges.

A dentist licensed under this chapter shall, when requested by a consumer:

(1) make a list of professional charges available for the consumer which includes the dentist's 25 most frequently performed:

(a) clinical procedures or clinical services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 25. Section **63M-1-2504** is amended to read:

63M-1-2504. Creation of Office of Consumer Health Services -- Duties.

(1) There is created within the Governor's Office of Economic Development the Office of Consumer Health Services.

(2) The office shall:

(a) in cooperation with the Insurance Department, the Department of Health, and the Department of Workforce Services, and in accordance with the electronic standards developed under Sections 31A-22-635 and 63M-1-2506, create [~~an~~] a Health Insurance Exchange as an Internet portal that:

(i) is capable of providing access to private and government health insurance websites and their electronic application forms and submission procedures;

(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the [~~Internet portal~~] Health Insurance Exchange by an insurer for the:

(A) small employer group market;

(B) the individual market; and

(C) the defined contribution arrangement market; and

(iii) includes information and a link to enrollment in premium assistance programs and other government assistance programs;

(b) facilitate a private sector method for the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others

by educating employers and insurers about collection services available through private vendors, including financial institutions;

(c) assist employers with a free or low cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars;

(d) periodically convene health care providers, payers, and consumers to monitor the progress being made regarding demonstration projects for health care delivery and payment reform; [~~and~~]

(e) establish a list on the Health Insurance Exchange of insurance producers who, in accordance with Subsection 31A-30-209, are appointed producers for defined contribution arrangements sold on the Health Insurance Exchange.

[~~(e)~~] (f) report to the Business and Labor Interim Committee and the Health Reform Task Force prior to [~~November 1, 2009 and~~] November 1, 2010, and prior to the Legislative interim day in November of each year thereafter regarding:

(i) the operations of the [~~Internet portal~~] Health Insurance Exchange required by this chapter; and

(ii) the progress of the demonstration projects for health care payment and delivery reform.

(3) The office:

(a) may not:

(i) regulate health insurers, health insurance plans, or health insurance producers;

(ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

(iii) act as an appeals entity for resolving disputes between a health insurer and an insured; and

(b) may establish and collect a fee in accordance with Section 63J-1-504 for the transaction cost of:

(i) processing an application for a health benefit plan from the Internet portal to an insurer; and

(ii) accepting, processing, and submitting multiple premium payment sources.

Section 26. Section **63M-1-2506** is amended to read:

63M-1-2506. Health benefit plan information on Health Insurance Exchange -- Insurer transparency.

(1) (a) The office shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that:

(i) establish uniform electronic standards for:

(A) a health insurer to use when:

(I) transmitting information to [~~the Internet portal; or~~]:

(Aa) the Insurance Department under Subsection 31A-22-613.5(2)(a)(ii); and

(Bb) the Health Insurance Exchange as required by this section; or

(II) receiving information from the [~~Internet portal~~] Health Insurance Exchange; and

(B) facilitating the transmission and receipt of premium payments from multiple sources in the defined contribution arrangement market;

(ii) designate the level of detail that would be helpful for a concise consumer comparison of the items described in Subsections (4)[~~(a) through (d)~~] and (5) on the [~~Internet portal~~] Health Insurance Exchange; [~~and~~]

(iii) assist the risk adjuster board created under Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, and carriers participating in the defined contribution market on the [~~Internet portal~~] Health Insurance Exchange with the determination of when an employer is eligible to participate in the [~~Internet portal defined contribution market~~] Health Insurance Exchange under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements[~~.~~]; and

(iv) create an advisory board made up of health insurance producers who are registered with the Health Insurance Exchange and consumers to advise the exchange concerning the operation of the exchange and transparency issues.

(b) The office shall post or facilitate the posting of:

(i) the information required by this section on the [~~Internet portal~~] Health Insurance Exchange created by this part; and

(ii) links to websites that provide cost and quality information from the Department of Health Data Committee or neutral entities with a broad base of support from the provider and payer communities.

(2) A health insurer shall use the uniform electronic standards when transmitting information to the [~~Internet portal~~] Health Insurance Exchange or receiving information from the [~~Internet portal~~] Health Insurance Exchange.

(3) (a) (i) An insurer who participates in the defined contribution arrangement market

under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans offered in [~~that~~] the defined contribution arrangement market on the [~~Internet portal~~] Health Insurance Exchange and shall comply with the provisions of this section.

(ii) Beginning July 1, 2010, an insurer who offers a health benefit plan to a small employer group in the state shall post the health benefit plan on the Health Insurance Exchange and shall comply with the provisions of this section.

(b) An insurer who offers [~~products~~] individual health benefit plans under Title 31A, Chapter 30, Part 1, Individual and Small Employer Group:

(i) shall post on the Health Insurance Exchange the basic benefit plan required by Section 31A-22-613.5 [~~for individual and small employer group plans on the Internet portal if the insurer's plans are offered to the general public~~]; and

(ii) may publish on the Health Insurance Exchange any other health benefit plans that it offers [~~on the Internet portal; and~~] in the individual market.

(c) An insurer who posts a health benefit plan on the Health Insurance Exchange:

[~~(iii)~~] (i) shall comply with the provisions of this section for every health benefit plan it posts on the [~~Internet portal.~~] Health Insurance Exchange; and

(ii) may not offer products on the Health Insurance Exchange that are not health benefit plans.

(4) A health insurer shall provide the [~~Internet portal~~] Health Insurance Exchange with the following information for each health benefit plan submitted to the [~~Internet portal~~] Health Insurance Exchange:

(a) plan design, benefits, and options offered by the health benefit plan including state mandates the plan does not cover;

(b) provider networks;

(c) wellness programs and incentives; and

(d) descriptions of prescription drug benefits, exclusions, or limitations[~~; and~~].

[~~(c) at the same time as information is submitted under Subsection 31A-30-208(2), the following operational measures for each health insurer that submits information to the Internet portal:~~]

(5) (a) An insurer offering any health benefit plan in the state shall, in accordance with Section 32A-22-613.5, submit the information described in Subsection (5)(b) to the Insurance

Department in the electronic format required by Subsection (1).

(b) An insurer who offers a health benefit plan in the state shall submit to the Health Insurance Exchange the following operational measures:

(i) the percentage of claims paid by the insurer within 30 days of the date a claim is submitted to the insurer for the prior year; and

[~~(ii) the number of adverse benefit determinations by the insurer which were subsequently overturned on independent review under Section 31A-22-629 as a percentage of total claims paid by the insurer for the prior year.~~]

(ii) for all health benefit plans offered by the insurer in the state, the claims denial rate for the insurer determined in accordance with Subsection 31A-22-613.5(6).

(c) The Insurance Department shall forward to the Health Insurance Exchange the information submitted by an insurer in accordance with this section and Section 31A-22-613.5.

[~~(5)~~] (6) The Insurance Department shall post on the [~~Internet portal~~] Health Insurance Exchange the Insurance Department's solvency rating for each insurer who posts a health benefit plan on the [~~Internet portal~~] Health Insurance Exchange. The solvency rating for each carrier shall be based on methodology established by the Insurance Department by administrative rule and shall be updated each calendar year.

[~~(6)~~] (7) The commissioner may request information from an insurer under Section 31A-22-613.5 to verify the data submitted to the [~~Internet portal~~] Insurance Department and to the Health Insurance Exchange under this section.

[~~(7)~~] (8) A health insurer shall accept and process an application for a health benefit plan from the [~~Internet portal~~] Health Insurance Exchange in accordance with this section and Section 31A-22-635.

Section 27. **Repealer.**

This bill repeals:

Section **31A-30-105, Establishment of classes of business.**

Section **31A-30-106, Premiums -- Rating restrictions -- Disclosure.**

Section **31A-30-107.5, Preexisting condition exclusion -- Condition-specific exclusion riders -- Limitation periods.**

Section 28. **Health Reform Task Force -- Creation -- Membership -- Interim rules followed -- Compensation -- Staff.**

(1) There is created the Health Reform Task Force consisting of the following 11 members:

(a) four members of the Senate appointed by the president of the Senate, no more than three of whom may be from the same political party; and

(b) seven members of the House of Representatives appointed by the speaker of the House of Representatives, no more than five of whom may be from the same political party.

(2) (a) The president of the Senate shall designate a member of the Senate appointed under Subsection (1)(a) as a co-chair of the committee.

(b) The speaker of the House of Representatives shall designate a member of the House of Representatives appointed under Subsection (1)(b) as a co-chair of the committee.

(3) In conducting its business, the committee shall comply with the rules of legislative interim committees.

(4) Salaries and expenses of the members of the committee shall be paid in accordance with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override Sessions.

(5) The Office of Legislative Research and General Counsel shall provide staff support to the committee.

Section 29. **Duties -- Interim report.**

(1) The committee shall review and make recommendations on the following issues:

(a) the state's progress in implementing the strategic plan for health system reform as described in Section 63M-1-2505;

(b) the implementation of statewide demonstration projects to provide systemwide aligned incentives for the appropriate delivery of and payment for health care;

(c) the development of the defined contribution arrangement market and the plan developed by the risk adjuster board for implementation by January 1, 2012, including:

(i) increased selection of health benefit plans in the defined contribution market;

(ii) participation by large employer groups in the defined contribution market; and

(iii) risk allocation in the defined contribution market;

(d) the operations and progress of the Health Insurance Exchange;

(e) mechanisms to increase transparency in the insurance market;

(f) the implementation and effectiveness of insurer wellness programs and incentives, including outcome measures for the programs;

(g) developing with providers and insurers a more efficient process for pre-authorization from an insurer for a medical procedure;

(h) the role that the Public Employees Health Program and other associations that provide insurance may play in the defined contribution market portal;

(i) the development of strategies to keep community leaders, business leaders, and the public involved in the process of health care reform; and

(j) the state's response to, and duties under federal health care reform efforts.

(2) A final report shall be presented to the Business and Labor Interim Committee before November 30, 2010.

Section 30. **Effective date.**

If approved by two-thirds of all the members elected to each house, this bill takes effect upon approval by the governor, or the day following the constitutional time limit of Utah Constitution Article VII, Section 8, without the governor's signature, or in the case of a veto, the date of veto override, except that:

(1) the amendments to Section 31A-30-103 take effect on July 1, 2011; and

(2) Section 27 of this bill which repeals Sections 31A-30-105, 31A-30-106, and 31A-30-107.5, takes effect July 1, 2011.